

(b) Reductions in portion of other cost sharing amounts the M+C organization charges to the beneficiary.

(c) The addition of benefits that may require additional premium and cost sharing. The addition of benefits and the charges for those benefits are not subject to HCFA review or approval.

§ 422.108 Medicare secondary payer (MSP) procedures.

(a) *Basic rule.* HCFA does not pay for services to the extent that Medicare is not the primary payer under section 1862(b) of the Act and part 411 of this chapter.

(b) *Responsibilities of the M+C organization.* The M+C organization must, for each M+C plan—

(1) Identify payers that are primary to Medicare under section 1862(b) of the Act and part 411 of this chapter;

(2) Determine the amounts payable by those payers; and

(3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers.

(c) *Charges to other entities.* The M+C organization may charge, or authorize a provider to charge, other individuals or entities for covered Medicare services for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.

(d) *Charge to other insurers or the enrollee.* If a Medicare enrollee receives from an M+C organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the M+C organization may charge, or authorize a provider to charge any of the following—

(1) The insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and part 411 of this chapter.

(2) The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

(e) *Charge to group health plans (GHPs) and large group health plans (LGHPs).* An M+C organization may charge a GHP or LGHP for services it furnishes to a Medicare enrollee who is

also covered under the GHP or LGHP and may charge the Medicare enrollee to the extent that he or she has been paid by the GHP or LGHP.

§ 422.109 Effect of national coverage determinations (NCDs).

(a) If HCFA determines and announces that an NCD meets the criteria for "significant cost" described in paragraph (c) of this section, an M+C organization is not required to assume risk for the costs of that service until the contract year for which the annual M+C capitation rate is determined on a basis that includes the cost of the NCD service.

(b) The M+C organization must furnish, arrange or pay for an NCD "significant cost" service prior to the adjustment of the annual M+C capitation rate. The following rules apply to such services:

(1) Medicare payment for the service is:

(i) In addition to the capitation payment to the M+C organization; and

(ii) Made directly by the fiscal intermediary and carrier to the M+C organization in accordance with original Medicare payment rules, methods, and requirements.

(2) NCD costs for which HCFA intermediaries and carriers will not make payment and are the responsibility of the M+C organization are—

(i) Services necessary to diagnose a condition covered by the NCD;

(ii) Most services furnished as follow-up care to the NCD service;

(iii) Any service that is already a Medicare-covered service and included in the annual M+C capitation rate; and

(iv) Any service, including the costs of the NCD service itself, to the extent the M+C organization is already obligated to cover it as an additional benefit under § 422.312 or supplemental benefit under § 422.102.

(3) NCD costs for which HCFA intermediaries and carriers make payment are—

(i) Costs relating directly to the provision of services related to the NCD that were noncovered services prior to the issuance of the NCD; and

(ii) A service that is not included in the M+C per capita payment rate.

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(4) If the M+C organization does not provide or arrange for the service consistent with HCFA's NCD, enrollees may obtain the services through qualified providers not under contract to the M+C organization, and the organization will pay for the services consistent with § 422.109(c).

(5) Beneficiaries are liable for Part A deductible and any applicable coinsurance amounts.

(c) The term "significant cost" as it relates to a particular NCD means either of the following:

(1) The average cost of furnishing a single service exceeds a cost threshold that—

(i) For calendar years 1998 and 1999, is \$100,000;

(ii) For calendar year 2000 and subsequent calendar years, is the preceding year's dollar threshold adjusted to reflect the national per capita growth percentage described in § 422.254(b).

(2) The estimated cost of all of Medicare services furnished nationwide as a result of a particular NCD represents at least 0.1 percent of the national standardized annual capitation rate (see § 422.254(f)), multiplied by the total number of Medicare beneficiaries nationwide for the applicable calendar year.

§ 422.110 Discrimination against beneficiaries prohibited.

(a) *General prohibition.* Except as provided in paragraph (b) of this section, an M+C organization may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an M+C plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following:

(1) Medical condition, including mental as well as physical illness.

(2) Claims experience.

(3) Receipt of health care.

(4) Medical history.

(5) Genetic information.

(6) Evidence of insurability, including conditions arising out of acts of domestic violence.

(7) Disability.

(b) *Exception.* An M+C organization may not enroll an individual who has been medically determined to have

end-stage renal disease. However, an enrollee who develops end-stage renal disease while enrolled in a particular M+C organization may not be disenrolled for that reason. An individual who is an enrollee of a particular M+C organization, and resides in the M+C plan service area at the time he or she first becomes M+C eligible, is considered to be "enrolled" in the M+C organization for purposes of the preceding sentence.

(c) Plans are required to observe the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, and Americans with Disabilities Act (see § 422.502(h)).

[63 FR 35077, June 26, 1998; 63 FR 52612, Oct. 1, 1998; 64 FR 7980, Feb. 17, 1999]

§ 422.111 Disclosure requirements.

(a) *Detailed description of plan provisions.* An M+C organization must disclose the information specified in § 422.64 and in paragraph (b) of this section—

(1) To each enrollee electing an M+C plan it offers;

(2) In clear, accurate, and standardized form; and

(3) At the time of enrollment and at least annually thereafter.

(b) *Content of plan description.* The description must include the following information:

(1) *Service area.* The M+C plan's service area and any enrollment continuation area.

(2) *Benefits.* The benefits offered under the plan, including applicable conditions and limitations, premiums and cost-sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with receipt or use of benefits; and for purposes of comparison—

(i) The benefits offered under original Medicare, including the content specified in § 422.64(c);

(ii) For an M+C MSA plan, the benefits under other types of M+C plans; and

(iii) The availability of the Medicare hospice option and any approved hospices in the service area, including those the M+C organization owns, controls, or has a financial interest in.

(3) *Access.* The number, mix, and distribution (addresses) of providers from